In the Matter of the Winding Down of: The New Hampshire Medical Malpractice Joint Underwriting Association, Merrimack Superior Court No. 217-2015-CV-00347

HEALTH CARE PROVIDER ADDRESS CONFIRMATION

I submit this form to obtain a return of funds from the Stabilization Reserve Fund of the New Hampshire Medical Malpractice Joint Underwriting Association for a provider identified on the SRF Return Provider List posted on the website of the New Hampshire Insurance Department.

1. a. Provider Ref. # from the SRF Return Provider List: _____

   b. Provider Name from the SRF Return Provider List: _____

2. Current Provider Name: _____

   If different from the name on the SRF Return Provider List set forth in No. 1 above, attach a statement explaining the relationship between you and the provider in No. 1 and why you are entitled to receive the SRF return for the provider in No. 1.

   Statement attached: Yes ____ No _____

3. Provider's Current Address: _____

   _____

   _____

4. Provider's telephone number: _____

5. Provider's email address: _____

I confirm that the provider or successor identified in Numbers 2-5 above is entitled to receive the SRF return for the provider identified in No. 1 above and that the information provided on this confirmation form is accurate.

Executed under the penalties of perjury this ____ day of _____, 2018.

Signature: _____

Person signing (print): _____

Please return this address confirmation form on or before July 26, 2018 to:

Receiver, NHMMJUA
P.O. Box 1720
Manchester, NH 03105-1720